

Covered California
Standard Benefit Plan Designs - FINAL
Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE
 ENROLLEE'S OUT OF POCKET COSTS

7/18/2013

Actuarial Value - Final AV Calculator

Overall deductible

Other deductibles for specific services

Medical

Brand Drugs

Dental

Out-of-pocket limit on expenses

Platinum
Coinsurance Plan

Platinum
Copay Plan

88.1%

88.0%

\$0

\$0

\$0

\$0

\$0

\$0

See attachment

See attachment

\$4,000

\$4,000

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$20		\$20	
	Specialist visit	\$40		\$40	
	Other practitioner office visit	\$20		\$20	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	\$20		\$20	
	X-rays and Diagnostic Imaging	\$40		\$40	
	Imaging (CT/PET scans, MRIs)	10%		\$150	
Drugs to treat illness or condition	Generic drugs	\$5		\$5	
	Preferred brand drugs	\$15		\$15	
	Non-preferred brand drugs	\$25		\$25	
	Specialty drugs	10%		10%	
Outpatient surgery	Facility fee (e.g., ASC)	10%		\$250	
	Physician/surgeon fees	10%			
	Emergency room services (waived if admitted)	\$150		\$150	
	Emergency medical transportation	\$150		\$150	
Need immediate attention					
	Urgent care	\$40		\$40	
Hospital stay	Facility fee (e.g., hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20		\$20	
	Mental/Behavioral health inpatient services	10%		\$250 per day up to 5 days	
	Substance use disorder outpatient services	\$20		\$20	
	Substance use disorder inpatient services	10%		\$250 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services	10%		\$250 per day up to 5 days	
	Home health care	10%		\$20	
	Rehabilitation services	\$20		\$20	
Help recovering or other special health needs	Habilitation services	\$20		\$20	
	Skilled nursing care	10%		\$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No cost share		No cost share	
Child needs dental or eye care	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	Pediatric Dental Standard Plan Design attached		Pediatric Dental Standard Plan Design attached	
	Dental Basic Services				
	Dental Restorative and Orthodontia Services				

Notes:

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.

2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.

5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

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	Gold Coinsurance Plan	Gold Copoly Plan
Overall deductible	\$0	\$0
Other deductibles for specific services		
Medical	\$0	\$0
Brand Drugs	\$0	\$0
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$6,350	\$6,350

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$30		\$30	
	Specialist visit	\$50		\$50	
	Other practitioner office visit	\$30		\$30	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	\$30		\$30	
	X-rays and Diagnostic Imaging	\$50		\$50	
	Imaging (CT/PET scans, MRIs)	20%		\$250	
Drugs to treat illness or condition	Generic drugs	\$19		\$19	
	Preferred brand drugs	\$50		\$50	
	Non-preferred brand drugs	\$70		\$70	
	Specialty drugs	20%		20%	
Outpatient surgery	Facility fee (e.g., ASC)	20%		\$600	
	Physician/surgeon fees	20%			
	Emergency room services (waived if admitted)	\$250		\$250	
Need immediate attention	Emergency medical transportation	\$250		\$250	
	Urgent care	\$60		\$60	
Hospital stay	Facility fee (e.g., hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee	20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$30		\$30	
	Mental/Behavioral health inpatient services	20%		\$600 per day up to 5 days	
	Substance use disorder outpatient services	\$30		\$30	
	Substance use disorder inpatient services	20%		\$600 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services	20%		\$600 per day up to 5 days	
	Home health care	20%		\$30	
Help recovering or other special health needs	Rehabilitation services	\$30		\$30	
	Habilitation services	\$30		\$30	
	Skilled nursing care	20%		\$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
Child needs dental or eye care	Hospice service	No cost share		No cost share	
	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	Pediatric Dental Standard Plan Design attached		Pediatric Dental Standard Plan Design attached	
	Dental Basic Services				
	Dental Restorative and Orthodontia Services				

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Overall deductible

Other deductibles for specific services

Medical

Brand Drugs

Dental

Out-of-pocket limit on expenses

		Individual		Individual	
		Silver Coinsurance Plan		Silver Copay Plan	
		69.7%		69.2%	
		N/A		N/A	
		\$2,000		\$2,000	
		\$250		\$250	
		See attachment		See attachment	
		\$6,350		\$6,350	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$45		\$45	
	Specialist visit	\$65		\$65	
	Other practitioner office visit	\$45		\$45	
Tests	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	\$45		\$45	
	X-rays and Diagnostic Imaging	\$65		\$65	
Drugs to treat illness or condition	Imaging (CT/PET scans, MRIs)	20%	X	\$250	
	Generic drugs	\$19		\$19	
	Preferred brand drugs	\$50	X	\$50	X
Outpatient surgery	Non-preferred brand drugs	\$70	X	\$70	X
	Specialty drugs	20%	X	20%	X
	Facility fee (e.g., ASC)	20%		20%	
Need immediate attention	Physician/surgeon fees	20%		20%	
	Emergency room services (waived if admitted)	\$250	X	\$250	X
	Emergency medical transportation	\$250	X	\$250	X
Hospital stay	Urgent care	\$90		\$90	
	Facility fee (e.g., hospital room)	20%	X	20%	X
	Physician/surgeon fee	20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$45		\$45	
	Mental/Behavioral health inpatient services	20%	X	20%	X
	Substance use disorder outpatient services	\$45		\$45	
Pregnancy	Substance use disorder inpatient services	20%	X	20%	X
	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services	20%	X	20%	X
Help recovering or other special health needs	Home health care	20%		\$45	
	Rehabilitation services	\$45		\$45	
	Habilitation services	\$45		\$45	
Child needs dental or eye care	Skilled nursing care	20%	X	20%	X
	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	Pediatric Dental Standard Plan Design attached		Pediatric Dental Standard Plan Design attached	
	Dental Basic Services				
	Dental Restorative and Orthodontia Services				

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Overall deductible
 Other deductibles for specific services

Medical
 Brand Drugs
 Dental

Out-of-pocket limit on expenses

SHOP		SHOP	
Silver Coinsurance Plan		Silver Copay Plan	
70.7%		70.3%	
N/A		N/A	
\$1,500		\$1,500	
\$500		\$500	
See attachment		See attachment	
\$6,350		\$6,350	
Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
\$45		\$45	
\$65		\$65	
\$45		\$45	
No cost share		No cost share	
\$45		\$45	
\$65		\$65	
20%	X	\$250	
\$19		\$19	
\$50	X	\$50	X
\$70	X	\$70	X
20%	X	20%	X
20%		20%	
20%		20%	
\$250	X	\$250	X
\$250	X	\$250	X
\$90		\$90	
20%	X	20%	X
20%			
\$45		\$45	
20%	X	20%	X
\$45		\$45	
20%	X	20%	X
No cost share		No cost share	
20%	X	20%	X
20%			
20%		\$45	
\$45		\$45	
\$45		\$45	
20%	X	20%	X
20%		20%	
No cost share		No cost share	
0%		0%	
1 pair per year		1 pair per year	
Pediatric Dental Standard Plan Design attached		Pediatric Dental Standard Plan Design attached	

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Overall deductible

Other deductibles for specific services

Medical

Brand Drugs

Dental

Out-of-pocket limit on expenses

SHOP

Silver
HSA Plan

71.5%

\$1,500 integrated Med/Rx

N/A

N/A

See attachment

\$6,350

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	20%	X
	Specialist visit	20%	X
	Other practitioner office visit	20%	X
	Preventive care/ screening/ immunization	No cost share	
Tests	Laboratory Tests	20%	X
	X-rays and Diagnostic Imaging	20%	X
	Imaging (CT/PET scans, MRIs)	20%	X
	Generic drugs	20%	X
Drugs to treat illness or condition	Preferred brand drugs	20%	X
	Non-preferred brand drugs	20%	X
	Specialty drugs	20%	X
	Facility fee (e.g., ASC)	20%	X
Outpatient surgery	Physician/surgeon fees	20%	X
	Emergency room services (waived if admitted)	20%	X
	Emergency medical transportation	20%	X
Need immediate attention	Urgent care	20%	X
Hospital stay	Facility fee (e.g., hospital room)	20%	X
	Physician/surgeon fee	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20%	X
	Mental/Behavioral health inpatient services	20%	X
	Substance use disorder outpatient services	20%	X
	Substance use disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception visits	No cost share	
	Delivery and all inpatient services	20%	X
	Professional	20%	X
	Home health care	20%	X
Help recovering or other special health needs	Rehabilitation services	20%	X
	Habilitation services	20%	X
	Skilled nursing care	20%	X
	Durable medical equipment	20%	X
Child needs dental or eye care	Hospice service	No cost share	X
	Eye exam (deductible waived)	0%	
	Glasses	1 pair per year	
	Dental check-up - Preventive and Diagnostic	Pediatric Dental Standard Plan Design attached	
	Dental Basic Services		
	Dental Restorative and Orthodontia Services		

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	Silver Coinsurance Plan 100%-150% FPL	Silver Coinsurance Plan 150%-200% FPL
Overall deductible	\$0	N/A
Other deductibles for specific services		
Medical	\$0	\$500
Brand Drugs	\$0	\$50
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$2,250	\$2,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$3		\$15	
	Specialist visit	\$5		\$20	
	Other practitioner office visit	\$3		\$15	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	\$3		\$15	
	X-rays and Diagnostic Imaging	\$5		\$20	
	Imaging (CT/PET scans, MRIs)	10%		15%	X
Drugs to treat illness or condition	Generic drugs	\$3		\$5	
	Preferred brand drugs	\$5		\$15	X
	Non-preferred brand drugs	\$10		\$25	X
	Specialty drugs	10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)	10%		15%	
	Physician/surgeon fees	10%		15%	
	Emergency room services (waived if admitted)	\$25		\$75	X
	Emergency medical transportation	\$25		\$75	X
Need immediate attention	Urgent care	\$6		\$30	
Hospital stay	Facility fee (e.g., hospital room)	10%		15%	X
	Physician/surgeon fee	10%		15%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$3		\$15	
	Mental/Behavioral health inpatient services	10%		15%	X
	Substance use disorder outpatient services	\$3		\$15	
	Substance use disorder inpatient services	10%		15%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services	10%		15%	X
	Professional	10%		15%	
Help recovering or other special health needs	Home health care	10%		15%	
	Rehabilitation services	\$3		\$15	
	Habilitation services	\$3		\$15	
	Skilled nursing care	10%		15%	X
Child needs dental or eye care	Durable medical equipment	10%		15%	
	Hospice service	No cost share		No cost share	
	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	Pediatric Dental Standard Plan Design attached		Pediatric Dental Standard Plan Design attached	
	Dental Basic Services				
	Dental Restorative and Orthodontia Services				

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Silver Coinsurance Plan
200%-250% FPL

74.0%

Overall deductible

N/A

Other deductibles for specific services

Medical

\$1,500

Brand Drugs

\$250

Dental

See attachment

Out-of-pocket limit on expenses

\$5,200

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$40	
	Specialist visit	\$50	
	Other practitioner office visit	\$40	
	Preventive care/ screening/ immunization	No cost share	
Tests	Laboratory Tests	\$40	
	X-rays and Diagnostic Imaging	\$50	
	Imaging (CT/PET scans, MRIs)	20%	X
Drugs to treat illness or condition	Generic drugs	\$19	
	Preferred brand drugs	\$30	X
	Non-preferred brand drugs	\$50	X
	Specialty drugs	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%	
	Physician/surgeon fees	20%	
	Emergency room services (waived if admitted)	\$250	X
	Emergency medical transportation	\$250	X
Need immediate attention	Urgent care	\$80	
Hospital stay	Facility fee (e.g., hospital room)	20%	X
	Physician/surgeon fee	20%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$40	
	Mental/Behavioral health inpatient services	20%	X
	Substance use disorder outpatient services	\$40	
	Substance use disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception visits	No cost share	
	Delivery and all inpatient services	20%	X
	Professional	20%	
Help recovering or other special health needs	Home health care	20%	
	Rehabilitation services	\$40	
	Habilitation services	\$40	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
Child needs dental or eye care	Hospice service	No cost share	
	Eye exam (deductible waived)	0%	
	Glasses	1 pair per year	
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	Dental Restorative and Orthodontia Services		

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7/18/2013

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Overall deductible

Other deductibles for specific services

Medical

Brand Drugs

Dental

Out-of-pocket limit on expenses

Silver Copay Plan
 100%-150% FPL

Silver Copay Plan
 150%-200% FPL

94.9%

87.8%

\$0

N/A

\$0

\$500

\$0

\$50

See attachment

See attachment

\$2,250

\$2,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$3		\$15	
	Specialist visit	\$5		\$20	
	Other practitioner office visit	\$3		\$15	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	\$3		\$15	
	X-rays and Diagnostic Imaging	\$5		\$20	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Generic drugs	\$3		\$5	
Drugs to treat illness or condition	Preferred brand drugs	\$5		\$15	X
	Non-preferred brand drugs	\$10		\$25	X
	Specialty drugs	10%		15%	X
	Facility fee (e.g., ASC)	10%		15%	
Outpatient surgery	Physician/surgeon fees	10%		15%	
	Emergency room services (waived if admitted)	\$25		\$75	X
	Emergency medical transportation	\$25		\$75	X
Need immediate attention	Urgent care	\$6		\$30	
Hospital stay	Facility fee (e.g., hospital room)	10%		15%	X
	Physician/surgeon fee				
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$3		\$15	
	Mental/Behavioral health inpatient services	10%		15%	X
	Substance use disorder outpatient services	\$3		\$15	
	Substance use disorder inpatient services	10%		15%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services	10%		15%	X
	Hospital Professional				
Help recovering or other special health needs	Home health care	\$3		\$15	
	Rehabilitation services	\$3		\$15	
	Habilitation services	\$3		\$15	
	Skilled nursing care	10%		15%	X
	Durable medical equipment	10%		15%	
	Hospice service	No cost share		No cost share	
	Eye exam (deductible waived)	0%		0%	
Child needs dental or eye care	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	Pediatric Dental Standard Plan Design attached		Pediatric Dental Standard Plan Design attached	
	Dental Basic Services				
	Dental Restorative and Orthodontia Services				

Notes:

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
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Covered California
Standard Benefit Plan Designs - FINAL
Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE
 ENROLLEE'S OUT OF POCKET COSTS

7/18/2013		Silver Copay Plan 200%-250% FPL	
Actuarial Value - Final AV Calculator		73.6%	
Overall deductible		N/A	
Other deductibles for specific services			
Medical		\$1,500	
Brand Drugs		\$250	
Dental		See attachment	
Out-of-pocket limit on expenses		\$5,200	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$40	
	Specialist visit	\$50	
	Other practitioner office visit	\$40	
	Preventive care/ screening/ immunization	No cost share	
Tests	Laboratory Tests	\$40	
	X-rays and Diagnostic Imaging	\$50	
	Imaging (CT/PET scans, MRIs)	\$250	
Drugs to treat illness or condition	Generic drugs	\$19	
	Preferred brand drugs	\$30	X
	Non-preferred brand drugs	\$50	X
	Specialty drugs	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%	
	Physician/surgeon fees	20%	
	Emergency room services (waived if admitted)	\$250	X
	Emergency medical transportation	\$250	X
Need immediate attention	Urgent care	\$80	
Hospital stay	Facility fee (e.g., hospital room)	20%	X
	Physician/surgeon fee		
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$40	
	Mental/Behavioral health inpatient services	20%	X
	Substance use disorder outpatient services	\$40	
	Substance use disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception visits	No cost share	
	Delivery and all inpatient services	20%	X
	Hospital Professional		
Help recovering or other special health needs	Home health care	\$40	
	Rehabilitation services	\$40	
	Habilitation services	\$40	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
	Hospice service	No cost share	
	Eye exam (deductible waived)	0%	
Child needs dental or eye care	Glasses	1 pair per year	
	Dental check-up - Preventive and Diagnostic	Pediatric Dental Standard Plan Design attached	
	Dental Basic Services		
	Dental Restorative and Orthodontia Services		

Notes:

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
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Covered California
Standard Benefit Plan Designs - FINAL
Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE
 ENROLLEE'S OUT OF POCKET COSTS

7/18/2013

Actuarial Value - Final AV Calculator

Overall deductible
 Other deductibles for specific services

Medical
 Brand Drugs
 Dental

Out-of-pocket limit on expenses

Bronze Plan	Bronze HSA Plan
60.5%	59.0%
\$5,000 integrated Med/Rx	\$4,500 integrated Med/Rx
N/A	N/A
N/A	N/A
See attachment	See attachment
\$6,350	\$6,350

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$60	After 1st 3 non-preventive visits	40%	X
	Specialist visit	\$70	X	40%	X
	Other practitioner office visit	\$60	X	40%	X
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	30%	X	40%	X
	X-rays and Diagnostic Imaging	30%	X	40%	X
	Imaging (CT/PET scans, MRIs)	30%	X	40%	X
Drugs to treat illness or condition	Generic drugs	\$19	X	40%	X
	Preferred brand drugs	\$50	X	40%	X
	Non-preferred brand drugs	\$75	X	40%	X
	Specialty drugs	30%	X	40%	X
Outpatient surgery	Facility fee (e.g., ASC)	30%	X	40%	X
	Physician/surgeon fees	30%	X	40%	X
	Emergency room services (waived if admitted)	\$300	X	40%	X
	Emergency medical transportation	\$300	X	40%	X
Need immediate attention	Urgent care	\$120	After 1st 3 non-preventive visits	40%	X
Hospital stay	Facility fee (e.g., hospital room)	30%	X	40%	X
	Physician/surgeon fee	30%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$60	After 1st 3 non-preventive visits	40%	X
	Mental/Behavioral health inpatient services	30%	X	40%	X
	Substance use disorder outpatient services	\$60	After 1st 3 non-preventive visits	40%	X
	Substance use disorder inpatient services	30%	X	40%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services	30%	X	40%	X
	Professional	30%	X	40%	X
Help recovering or other special health needs	Home health care	30%	X	40%	X
	Rehabilitation services	30%	X	40%	X
	Habilitation services	30%	X	40%	X
	Skilled nursing care	30%	X	40%	X
Child needs dental or eye care	Durable medical equipment	30%	X	40%	X
	Hospice service	No cost share	X	No cost share	X
	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	Pediatric Dental Standard Plan Design attached		Pediatric Dental Standard Plan Design attached	
	Dental Basic Services				
	Dental Restorative and Orthodontia Services				

Notes:

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
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Covered California
Standard Benefit Plan Designs - FINAL
Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE
 ENROLLEE'S OUT OF POCKET COSTS

7/18/2013

Actuarial Value - Final AV Calculator

Catastrophic Plan

60.4%

Overall deductible

\$6,350 integrated Med/Rx

Other deductibles for specific services

Medical

N/A

Brand Drugs

N/A

Dental

See attachment

Out-of-pocket limit on expenses

\$6,350

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	0%	After 1st 3 non-preventive visits
	Specialist visit	0%	X
	Other practitioner office visit	0%	X
	Preventive care/ screening/ immunization	No cost share	
Tests	Laboratory Tests	0%	X
	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
Drugs to treat illness or condition	Generic drugs	0%	X
	Preferred brand drugs	0%	X
	Non-preferred brand drugs	0%	X
	Specialty drugs	0%	X
Outpatient surgery	Facility fee (e.g., ASC)	0%	X
	Physician/surgeon fees	0%	X
	Emergency room services (waived if admitted)	0%	X
	Emergency medical transportation	0%	X
Need immediate attention	Urgent care	0%	After 1st 3 non-preventive visits
Hospital stay	Facility fee (e.g., hospital room)	0%	X
	Physician/surgeon fee	0%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0%	After 1st 3 non-preventive visits
	Mental/Behavioral health inpatient services	0%	X
	Substance use disorder outpatient services	0%	After 1st 3 non-preventive visits
	Substance use disorder inpatient services	0%	X
Pregnancy	Prenatal care and preconception visits	No cost share	
	Delivery and all inpatient services	0%	X
	Hospital Professional	0%	X
Help recovering or other special health needs	Home health care	0%	X
	Rehabilitation services	0%	X
	Habilitation services	0%	X
	Skilled nursing care	0%	X
	Durable medical equipment	0%	X
	Hospice service	No cost share	X
	Eye exam (deductible waived)	0%	
Child needs dental or eye care	Glasses	1 pair per year	
	Dental check-up - Preventive and Diagnostic	Pediatric Dental Standard Plan Design attached	
	Dental Basic Services		
	Dental Restorative and Orthodontia Services		

Notes:

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California Health Benefit Exchange
Standard Pediatric Dental Essential Health Benefits Plan Design
Revised March 15, 2013

Procedure Categories	PPO High	PPO Low	DHMO High	DHMO Low
Diagnostic & Preventive (D&P) X-rays, Exams, Cleanings Sealants	Plan Pays: 100%	100%	Enrollee Pays: \$0	\$0
Office Visit	n/a	n/a	\$0	\$20
Basic Services - Basic Restorative	80%	50%	\$40 ³	\$95 ³
Major Services - Crowns & Casts, Prosthodontics, Endodontics, Periodontics, Oral Surgery	50%	50%	\$365 ⁴	\$365 ⁴
Orthodontics (Medically Necessary)	Enrollee Pays: 50%	50%	\$1,000	\$1,000
Deductible	\$50 (not applied to D&P)	\$60 (applied to all services)	None	None
Annual Maximum	None	None	None	None
OOP Maximum	\$1,000	\$1,000	\$1,000	\$1,000
Waiting Periods (Major & Ortho)	None	None	None	None
Actuarial Value (AV)	86%	72%	87%	72%

Notes:

1. Actuarial values are based on pediatric claims experience.
2. Orthodontics includes medically-necessary orthodontia only.
3. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average co-pay charged for procedures in this category cannot exceed the stated amount.
4. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average co-pay charged for procedures in this category cannot exceed the stated amount.